PHYSICIAN/HEARING SPECIALIST REPORT

Child's Name: ____ Age: ____________
Address: ____ Grade: ___________
School: ____

Results of Threshold Hearing Tests

RIGHT EAR						LEFT EAR					
250	500	1000	2000	4000	8000	250	500	1000	2000	4000	8000

PASS (P) OR FAIL (F)　　　　PASS (P) OR FAIL (F)

Physician's Audiogram Attached? ______Yes ______No

Tentative Diagnosis: ____

Type of Hearing Loss: ____

____

Prognosis: ____

____

Recommendations: ____

____
____
____

____
Physician's Name (Printed)

____　　　　___________________
(Physician's Signature)　　　　(Date)